

TRENTON BOARD OF EDUCATION

"Children Come First, Los niños son primero"

James Earle
Superintendent of Schools



Monica Carmichael
Director
Early Childhood Department
609.656.4960 • 609.393.0289 fax

ELIGIBILITY FOR PRESCHOOL REGISTRATION

Public schools are required to provide a free education to all persons over age 5 and under age 20 who are domiciled in the district. Domiciled means that the student is living with a parent or guardian whose permanent home is located within the boundaries of the district.

- A home is permanent when the person intends to return to it when absent and has no present plan to move from it, even though he/she has existence of homes or residences elsewhere.

- Residency requires bodily presence as an occupant in a given district.
If at any time, you or your child changes domicile or residence, you must report this information immediately to the school building secretary.

IT IS THE POLICY OF THE BOARD THAT SHOULD THE DISTRICT DISCOVER THAT A CHILD IS NOT A LEGAL RESIDENT OF THE DISTRICT AND IS ILLEGALLY ATTENDING TRENTON PUBLIC SCHOOLS, THE DISTRICT WILL ASSESS THE PARENTS THE FULL COSTS OF THE TUITION FOR SUCH ATTENDANCE. ANY ADDITIONAL COSTS FOR SPECIAL EDUCATION SERVICES WILL BE ADDED TO THE REGULAR EDUCATION COSTS.

Parent/Guardian of: _____ School: _____ Grade: _____

By my signature, I am indicating that I have read the information above, understand it, and affirm that my child(ren) and I are legal residents of and are domiciled in the Trenton Public School District.

Signed: _____ Date: _____

PLEASE RETURN THIS FORM TO THE SCHOOL FAMILY WORKER.
THIS COPY IS TO BE MAINTAINED IN THE STUDENT'S CUMULATIVE FOLDER.



Trenton Board of Education
 "Children come first, Los Nino's son primero"

Addendum to Registration Packet

Disclaimer: Trenton Public School district is collecting this information in an effort to ensure that all medical and health information is documented in a timely manner for new students entering district schools.

Name of Child (First and Last) _____

1. Did your child recently arrive in the United States? Circle one: Yes No
2. If YES, on what date did your child arrive? Month _____ Day _____ Year _____
3. Have you traveled from Sierra Leone in the last twenty-one (21) days? Circle one: Yes No
4. Have you traveled from Liberia in the last twenty-one (21) days? Circle one: Yes No
5. Have you traveled from Guinea in the last twenty-one (21) days? Circle one: Yes No

If you answered YES to questions three (3), four (4), or five (5), please proceed to question six (6). If you answered NO, proceed to the signature and date section.

6. Are you registering other children in any other school in district? Circle one: Yes No
7. If YES, list the names of each child and school you are registering them at below.

Name of Child (First and Last)	Name of school child will be or is registered at

I hereby authorize the district to release the responses to questions one (1) through five (5) to school-based staff (classroom teachers, paraprofessionals, nurse, and/or principal) who will interact with my child, _____.

Signature of person completing this form _____ Relationship to Child _____

Name of person completing this form (Please Print) _____ Date _____

Trenton Public School District Staff ONLY Registrar Initials: _____ Date" _____
 Registrar Instructions: Contact nurse when YES is indicated for questions three (3), four (4), or five (5)

- Copy with registration packet
- Copy to nurse
- Copy to principal for affirmative responses ONLY when YES is indicated for questions three (3), four (4), or five (5)

TRENTON BOARD OF EDUCATION

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HOME LANGUAGE SURVEY

PART A: HOME INSTRUCTION

Student's Name: _____ Date of Birth: _____

Parent/Guardian's Name: _____

Address: _____ (City/State/Zip)

Place of Birth: _____ School: _____

Teacher: _____ Grade: _____

PART B: LANGUAGE INFORMATION

1. What language did your child speak first?
 English Spanish Other _____
(Language)

2. What language do you speak most often to your child at home?
 English Spanish Other _____
(Language)

3. What language does your child most often speak when speaking at you home?
 English Spanish Other _____
(Language)

4. What language does your child use when speaking to: brothers/sisters?
 English Spanish Other _____
(Language)

5. What language does your child speak most often with other family members?
 English Spanish Other _____
(Language)

PART C: LANGUAGE SELECTION

What language do you prefer the school to send you communications? (Please indicate language below)

_____ Indicate Language

_____ Parent/Guardian Signature

_____ Date



TRENTON BOARD OF EDUCATION
 OFFICE OF EARLY CHILDHOOD
 929 Parkside Avenue
 Trenton, NJ 08618
 Phone (609) 656-4900 ext. 5667 Fax (609) 393-0809

Is the child Spanish, Hispanic or Latino? Mark one or mor group to indicate the child's Spanish/Hispanic/Latino origin.
 Es el nino Espanol, Hispano o Latino? Marque uno o mas grupos para indicar el origen Espanol, Hispano o Latino del nino.

<input type="checkbox"/>	No, not Spanish/Hispanic/Latino	No, No es Espano/Hispano/Latino
<input type="checkbox"/>	Yes, Mexican, Mexican American, Chicano	Si, Mejicano, Mejicano-Americano, Chicano
<input type="checkbox"/>	Yes, Puerto Rican	Si, Puerotriqueno
<input type="checkbox"/>	Yes, Cuban	Si, Cubano
<input type="checkbox"/>	Yes, other Spanish/Hispanic/Latino (Print group)	Si, Espano/Hispano/Latino de otro grupo (indique en letra de imprenta el grupo)

What language does the child speak most at home? Mark one box.
 Que lenguaje habla su hijo a habla en la casa? Marque una respuesta.

<input type="checkbox"/>	English	Ingles
<input type="checkbox"/>	Spanish	Espanol
<input type="checkbox"/>	Arabic	Arabe
<input type="checkbox"/>	Chinese	Chino
<input type="checkbox"/>	Creole (Hatian)	Creole (Haitiano)
<input type="checkbox"/>	Gujarati	Gujarati
<input type="checkbox"/>	Korean	Coreano
<input type="checkbox"/>	Polish	Polaco
<input type="checkbox"/>	Portugese	Portugues
<input type="checkbox"/>	Russian	Ruso
<input type="checkbox"/>	Urdu	Urdu
<input type="checkbox"/>	Some other Language (Print Language)	Otro Lenguaje (Indique el lenguaje)

Does the child have any chronic medical problems, special needs, or handicapping conditions? Mark one box
 Padece el nino de algun problema medico cronico, de necesidades especiales o algun tipo de incapacidad. Marque una respuesta

<input type="checkbox"/>	No	No
<input type="checkbox"/>	Yes (Pint problem or condition)	Si (Indique en letra de imprenta el problema o condicion.)

Will the child be enrolling for the entire school day?
 Su hijo/a sera matriculado para el dia entero escolar?

<input type="checkbox"/>	Yes, enrolling for the entire school day	Si, sera matriculado el dia entero
<input type="checkbox"/>	No, enrolling for half day	No, sera matriculado medio dia

What kind of health insurance does the child have?
 Que clase de seguro medico tiene el nino?

<input type="checkbox"/>	Private or employment-based health insurance	Seguro de salud privado o basado en el empleo
<input type="checkbox"/>	Medicaid	Medicaid
<input type="checkbox"/>	New Jersey Family Care	New Jersey Family Care
<input type="checkbox"/>	Some other health insurance	Otro tipo de seguro medico
<input type="checkbox"/>	Uninsured	No tiene seguro

TRENTON PUBLIC SCHOOLS
Trenton, New Jersey
Office of School Health Services

EC-5

DENTAL EXAMINATION/TREATMENT FORM

Section A: To be completed by parent/guardian

Pupil's Name: _____ Birthdate: _____

Address: _____

School/Grade: _____

Section B: To be completed by child's dentist

REPORT OF EXAMINATION

Please circle tooth (teeth) being treated

Tooth Chart																	
RIGHT											LEFT						
UPPER	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	UPPER
					A	B	C	D	E	F	G	H	I	J			
LOWER	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	LOWER
					T	S	R	Q	P	O	N	M	L	K			

Comments: Please check all that apply

- | | |
|---------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> fluoride treatment | <input type="checkbox"/> cavities treated |
| <input type="checkbox"/> sealants | <input type="checkbox"/> further treatment necessary |
| <input type="checkbox"/> cleaning | <input type="checkbox"/> treatment completed |
| <input type="checkbox"/> x-rays | _____ date of next appointment |

Printed Name of Dental/Examiner

Signature of Dental/Examiner

Date

Phone Number

Please return this form to your child's school once it is completed by the dentist.

TRENTON PUBLIC SCHOOLS
Trenton, New Jersey
Office of School Health Services

SH 2

PUPIL HEALTH HISTORY

Pupil's Name: _____ School: _____ Grade: _____
 Birthdate: _____ Sex: _____
 Address: _____ Telephone: _____
 Parent/Guardian's Name: _____ Telephone (Work): _____
 Usual Care Provider: (check) Private Physician ___ HMO ___ H.J. Austin Health Center ___ Clinic ___
 Doctor's Name: _____ Telephone number: _____

Health History and Development:

1. Length of pregnancy _____ months Delivery (circle one) Normal, Caesarian, Premature
 Birth weight _____ lbs _____ oz
 Problems at birth or delay sending newborn home. If yes, explain _____
2. Birth sequence of above child 1st _____ 2nd _____ 3rd _____ 4th _____ Other _____
3. What age did your child walk _____ talk _____ toilet-train _____
4. Does your child have any of the following problems?
 Vision _____ Hearing _____ Speech _____
5. Does your child take medications? Yes _____ No _____ If yes, explain _____
6. Is your child allergic to food, plants, dust, dogs, cats, bees, other? Yes _____ No _____
 If yes, explain _____
7. Has your child had a serious injury? Yes _____ Year _____ No _____
 If yes, explain _____
8. Has your child ever had an operation or medical procedure requiring outpatient services or hospitalization?
 Yes _____ Year _____ No _____
 If yes, explain _____
9. Has your child been tested for lead poisoning? Yes _____ No _____ Results _____

Disease History (Age)

Measles _____
 Scarlet Fever _____
 Pneumonia _____
 Convulsions _____
 Polio _____
 Heart Disease _____
 Anemia _____
 Frequent headaches _____
 Frequent nosebleeds _____

German Measles _____
 Whooping Cough _____
 Ear Infections _____
 Tubes in ears _____
 Sickle Cell _____
 Fractures _____
 Liver Disease _____
 Lyme Disease _____

Mumps _____
 Asthma _____
 Tuberculosis _____
 Chicken Pox _____
 Epilepsy _____
 Frequent Sore throats _____
 Diabetes _____
 Tonsillitis _____

Any restrictions or limitations to physical activity? _____
 Is there anything about your child's health not mentioned above that we should know?

Date _____

Signature of Parent/Guardian _____

CONFIDENTIAL INFORMATION

TRENTON PUBLIC SCHOOLS
Trenton, New Jersey
Office of School Health Services

SH 1

HEALTH ENROLLMENT CONSENT/NOTIFICATION FORM

Student's Name: _____

Date of Birth: _____

School: _____

Grade: _____

SIGNING IS CONSENT FOR MANDATED HEALTH SERVICES:

MEDICAL EXAMINATION

A medical examination is REQUIRED at time of entry to school:

- Students new to this district, and students in pre-school or Kindergarten
State mandate specifies that this medical exam be done by the student's own health care provider, with a full report sent to the school.

Please have your health care provider complete the UNIVERSAL CHILD HEALTH RECORD and return it to the school.

If your child does not have a private physician or health care provider, please understand that he/she will be scheduled for a new entry school medical examination.

THIS ALSO SERVES AS NOTICE OF THE OTHER MANDATED PROGRAMS:

TUBERCULOSIS (MANTOUX) TEST

A skin test for tuberculosis is done on all students entering from another country or an area designated by the NJ Department of Health and Human Services.

SCOLIOSIS SCREENING

A strip to the waist examination is done by the school nurse, and/or the school physician to determine whether your child's spine is developing straight. This screening is done every other year from 10 to 18 years of age.

HEALTH SCREENINGS

Screenings by the school nurse, as required by the State of New Jersey, include: height, weight, dental, vision, hearing, and blood pressure. You will be notified, by a referral form, if your child needs to have an examination by a health professional following these screenings.

Parent/Guardian Signature

Date

TRENTON BOARD OF EDUCATION

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Our school district is participating in a system where the federal government's Medicaid will pay state and local school districts for a portion of the costs of health-related special education services provided to Medicaid eligible children. **Your child will continue to receive services at no cost to you under this new system.** This initiative simply helps us maximize federal funds in support of local education. The information you voluntarily provide by completing this consent form will only be used for the purposes identified.

Please fill the information below, sign the form, and return it to the address indicated.

CONSENT FOR RELEASE OF INFORMATION TO ACCESS MEDICAID REIMBURSEMENT FOR HEALTH RELATED SUPPORT SERVICES

Child's Name: _____
(First) (MI) (Last)

Child's Date of Birth: _____
(Month) (Day) (Year)

As a parent/guardian of the child named above, I give permission to disclose information from my child's educational records to local, state, and federal agency representatives for the sole purpose of claiming Medicaid reimbursement for health related support services in my child's Individualized Education Program (IEP).

Signature: _____ Date: _____

Please return this form to:

TRENTON PUBLIC SCHOOL
Trenton, New Jersey
Office of School Health Services

MH-02

MEDICAL HOME INFORMATION FORM

Dear Parent/Guardian

In order to determine how many students have a medical home, it is necessary for you to complete the Medical Home Information Form. Please return the form to the school nurse.

Name of Student: _____

School: _____

Address: _____

Grade: _____

Phone Number: _____

Name of Health Care Provider: _____
(Doctor's Name or Clinic)

Address: _____

Phone Number: _____

Does your child have health insurance? Yes _____ No _____

If yes, name of insurance company: _____

.....
NJ Family Care Provides FREE or low cost health insurance for uninsured children, low income parents. You may release my name and address to the NJ Family Care Program to contact me about health insurance.

Print Name: _____

Signature: _____

Date: _____

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: American Academy of Pediatrics, New Jersey Chapter
New Jersey Academy of Family Physicians, New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)					
Child's Name (Last) (First)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /		
Does Child have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, Name of Child's Health Insurance Carrier			
Parent/Guardian Name		Home Telephone Number	Work Telephone/Cell Phone Number		
Parent/Guardian Name		Home Telephone Number	Work Telephone/Cell Phone Number		
I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.					
Signature/Date		This form may be released to WIC <input type="checkbox"/> Yes <input type="checkbox"/> No			
SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER					
Date of Physical Examination:		Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Abnormalities Noted:		Weight (must be taken within 30 days for WIC)			
		Height (must be taken within 30 days for WIC)			
		Head Circumference (if < 2 Years)			
		Blood Pressure (if > 3 Years)			
Immunizations		<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due:			
MEDICAL CONDITIONS					
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments		
Medications/Treatments • List medications/treatments		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments		
Limitations to Physical Activity • List limitations/special considerations:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments		
Special Equipment Needs • List items necessary for daily activities:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments		
Allergies/Sensitivities • List dietary specifications:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments		
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments		
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments		
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments		
PREVENTATIVE HEALTH SCREENINGS					
Type of Screening	Date Performed	Record Value	Type Screening	Date Performed	Note If Abnormal
Hgb/Hct			Hearing		
Led <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		
<input type="checkbox"/> I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.					
Name of Health Care Provider (Print)					
Signature/Date					
Health Care Provider Stamp:					

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 – Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to sign discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 – Health Care Provider

1. Please enter the date of the physical exam **that is being used to complete the form**. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing, etc.)
 - a. Weight – Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
 - b. Height – Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
 - c. Head Circumference – Only enter if the child is less than 2 years
 - d. Blood Pressure – Only enter if the child is 3 years or older

2. **Immunization** – A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860.
 - a. The Immunization record must be attached for the form to be valid
 - b. “Date next immunization is due” is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions** – Please list any ongoing medical conditions that might impact the child’s health and well-being in the child care or school setting.
 - a. Note any significant medical conditions or major surgical history. If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issues blocks that follow. A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch_15.doc or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.
 - b. Medications – List any ongoing medications, include any medications given at home if they might impact the child’s health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included. PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration. Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.
 - c. Limitations to physical activity – Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Not, any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.
 - d. Special Equipment – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.
 - e. Allergies/Sensitivities – Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.
 - f. Special Diets – Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.
 - g. Behavioral/Mental Health issues – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, Or ADHD.
 - h. Emergency Plans – May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** – This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public health personnel to track children’s health. Please enter the date the test was performed. Not if the test was abnormal or plan n “N” if it was normal.
 - a. For lead screening state if the blood sample was capillary or venous and the value of the test performed.
 - b. For PPD enter millimeters of induration, and the date listed should be the date read. If the chest x-ray was done, record results.
 - c. Scoliosis screening are done biennially in the public schools beginning at age 10.This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
 - a. Print the health care provider’s name.
 - b. Stamp with health care site’s name, address and phone number.

Trenton Public School District, Office of Early Childhood
Preschool Family Survey



The Office of Early Childhood has developed the following survey in effort to benefit preschool family needs. Input from this survey will help us design parent involvement programs that best fit the needs of our families. The survey information will be kept confidential. We realize your time is very limited and we thank you for completing this survey. Please contact Sheree Dublin, Community & Parent Involvement Specialist at (609) 656-4900 ext. 5669.

Please complete the survey below.

1. What is your relationship to the enrolled preschool student?

a. Mother Father

b. Legal Guardian (Individual Raising child)

Language(s) spoken at home: _____

2. Which of the following topics would you like to learn more about during this school year? (check all that apply)

- | | |
|---------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Discipline/Behavior | <input type="checkbox"/> Stages of Child Development |
| <input type="checkbox"/> Nutrition | <input type="checkbox"/> Preschool Curriculum |
| <input type="checkbox"/> Health and Safety | <input type="checkbox"/> Sibling Rivalry |
| <input type="checkbox"/> Bedtime Strategies | <input type="checkbox"/> Ways to Raise a Reader |
| <input type="checkbox"/> Supporting Math Skills at Home | <input type="checkbox"/> College Saving Plans |
| <input type="checkbox"/> Preparing for Kindergarten | <input type="checkbox"/> Science can be Fun |
| <input type="checkbox"/> Other: _____ | |

3. What is the best time for you to participate in workshops or activities?

a. Morning (between 8:30am and 12 noon)

b. Afternoon (between 12 noon and 4pm)

c. Evening (between 4pm and 7pm)

4. How did you find out about the Preschool program? (Please check all that apply)

- | | |
|------------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> Flyer sent home | <input type="checkbox"/> Flyer or poster in a business or agency |
| <input type="checkbox"/> Childcare | <input type="checkbox"/> Heard it from friend or relative |
| <input type="checkbox"/> Newspaper | <input type="checkbox"/> District local channel |
| <input type="checkbox"/> Other: _____ | |

5. What is the most effective way to inform you of workshops/activities/meetings?

Flyer Phone Calls

Email Staff

Other: _____

6. Do you have internet access at home? (Please check all that apply)

Phone Computer at home

Computer at Work

Other: _____

7. Would you be interested in obtaining information about any of the following services? If yes, please provide your contact information.

Name: _____

Phone number: _____

Parenting Classes

Social Services

Legal Services

Adult Education Classes

Parent Support Groups

Other: _____

Child's Name: _____

Center Location: _____

Job Training Opportunities

English Language Classes

Money Management Classes

Health Insurance/NJ Family Care

WIC Nutrition Program

8. Does your family have any special talents that you would be willing to share with our preschool students? (i.e. Musical talents, cooking talents, artistic talents, etc.) If so, please explain and provide contact information.

Name: _____ Phone Number: _____

9. What do you think is the best way schools and families can work together to support students?

TRENTON PUBLIC SCHOOLS

"Children come First, Los niños son primero"

James Earle
Superintendent of Schools



State of New Jersey

County of Mercer

Resident Affidavit

I, _____, hereby certify to the following:
(Name of Landlord/Property Manager)

1. I am the tenant/owner of property located at: _____, in the City
of Trenton, Mercer County, New Jersey.

2. This residence or residential unit is currently underlease or is being occupied by the following person(s) in addition to
our own family members.

3. The person(s) identified in response to #2 above has/have occupied the above premises as their sole or main residence,
or domicile since the following date: _____

4. This Affidavit is submitted for the purpose of inducing the Trenton Board of Education to accept the child as a student
in the Trenton Public School District on a tuition-free basis. If any of the statements contained in this affidavit are
willfully false, I am aware that I am subject to penalties provided by law for making such false statement. (N.J.S.A.
18a:38-1 ©, N.J.A.C. 6a:22-3, N.J.S.A. 2C:28-2)

Landlord (Print Name)

Landlord (Print Name)

Landlord (Signature)

Landlord (Signature)

NOTARY USE ONLY

Sworn to and subscribed before me this _____ day of _____, 20_____

(Notary Stamp Here)

NOTARY USE ONLY	
Sworn to and subscribed before me this _____ day of _____, 20_____	(Notary Stamp Here)